

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03888

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 4 N. Hill St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Barbara Bromwell

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 8 1934

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

51015

hrs.

min.

9. Birthplace Cambridge Md
(Town, county, and state)10. Usual occupation none

11. Industry or business

FATHER 12. Name Joe. Bromwell13. Birthplace Madison MdMOTHER 14. Maiden name Nellie Allen15. Birthplace Cambridge Md16. Informant Nellie Allen BromwellAddress 4 N. Hill St17. Buried
(Burial, cremation, or removal. Which?)Date thereof April 25 1945
(month) (day) (year)Cemetery or crematory Wauke CemeteryLocation Hill St Cambridge Md18. Funeral director Lewis BayneAddress Cambridge Md19. 4-25-45 John Marshall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945 at 3:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22 1945 to April 23 1945and that I last saw him alive on April 23 1945

Immediate cause of death

Influenza Pneumonia

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. St. Clair

M. D. or other

Address 4 N. Hill St Date signed 4-24-45

RECEIVED BY THE STATE DEPARTMENT

APR 27 1945

RECEIVED
APR 27 1945
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03889

Reg. Dist. No. 110

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

78

11

7

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

17.

(Burial, cremation, or removal, which?)

Date thereat.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19.

(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

1945, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

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MAY 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03890

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

119 Vue du leau St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 119nVue du leau St.
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Aurelia E. Dashiell

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

B.(b) Name of husband or wife

-6.(c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.) Nov. 10, 1861.

8. AGE:

Years

83

Months

4

Days

24

It less than one day

- hrs. - min.9. Birthplace Nr. Cambridge, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

Retired

FATHER

12. Name

Edwin Dashiell

13. Birthplace

Maryland.

MOTHER

14. Maiden name

Ellen Gordon

15. Birthplace

Not Known

18. Informant

Edwin D. Hirst

Address

Dambridge, Maryland.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof April 6, 1945
(month) (day) (year)

Cemetery or crematory

Christ Church Cemetery

Location

Cambridge, Maryland.

18. Funeral director

LeCompte's Funeral Service

Address

Cambridge, Maryland.

19.

(Date rec'd by registrar)

4-6-

19.

45John M. Hirst

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw h. - alive on 19

Immediate cause of death

DURATION

Exhaustion

Due to

Carcinoma of Breast 8-10 yrs.

Due to

and metastases into chest and upper abdomen

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. -

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -

Means of injury

Injured at work? -

23. SIGNATURE

Jo. K. Shriner, Dep. Med. Exam.

M. D. or other

Address Cambridge, Md. Date signed April 5/45

RECEIVED

APR 9 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

03891

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Cambridge-md. Hospital, INC.

How long in hospital or institution?

15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Dorchester
 City or town ELIOTS
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

ETHEL DAYTON

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 1st 1905

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

404

hrs.

min.

9. Birthplace

MARYLAND
(Town, county, and state)

10. Usual occupation

HOUSEWORK

11. Industry or business

MOTHER FATHER

12. Name

Alvin Dayton

13. Birthplace

MARYLAND

14. Maiden name

Hunley

15. Birthplace

MARYLAND

18. Informant

Hospital Records

Address

Cambridge

17.

(Burial, cremation, or removal, which?)

Date thereof

April 30 1945
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Elm Street

18. Funeral director

H. B. McLaughlin

Address

East New Market

19.

(Date rec'd by registrar)

19.

April 30th 1945
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28 19 45 at 12:09 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APRIL 27 19 45 to APRIL 28 19 45and that I last saw him/her alive on APRIL 27 19 45

Immediate cause of death

MYOCARDIAL FAILURE

DURATION

2 days

Due to

PERITONITIS?

Due to

Ruptured Appendix?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. [Signature]
Address Cambridge Md

M. D. or other

Date signed 4/28/45

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MAY 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4629

CERTIFICATE OF DEATH

Reg. Dist. No. 115

03892

1. PLACE OF DEATH:

County DorchesterCity or town Hoopersville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Hoopersville
(If outside city or town limits, write RURAL and give nearest town)Street No. near Brad Lyers drive
(If rural, give LOCATION)2.(a) If veteran, name war W

3. (a) FULL NAME

William Edward Dorsey
on Social Security Card - name is William H. Dorsey

3. (b) Social Security Number

217-03-5230

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Katie A. Dorsey6. (c) If alive, give age 59 years

7. Birth date of

deceased (mo., day, yr.)

July 4 - 1885

8. AGE:

Years

59

Months

9

Days

22

If less than one day

hrs.

min.

9. Birthplace

Hoopersville Md.
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Seafood & Tom Tor Packer

FATHER

12. Name

Bill Dorsey

13. Birthplace

Maryland - Church Creek

MOTHER

14. Maiden name

Phonix Ross

15. Birthplace

Hoopersville Md

16. Informant

Katie A. Dorsey

Address

Hoopersville, Md

17. Burial

Buried

Date thereof

April 29 - 1945
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Camden

Location

Hoopersville Md

18. Funeral director

L. H. Bayneum

Address

201 Washington Street, Cambridge Md

19. April 29

1945

(Date rec'd by registrar)

James W. Meade
LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26 1945, at 8³⁰ a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 1945, to April 26 1945and that I last saw him alive on April 26 1945

Immediate cause of death

Carcinoma of Colon

DURATION

Multiple metastasisChest & Liver

Due to

Multiple metastasis

Due to

Multiple metastasis

Due to

Multiple metastasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Multiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasisMultiple metastasis

23. SIGNATURE

James W. Meade, M.D.

Address

201 Washington Street, Cambridge Md

Date signed

April 27

RECEIVED

CERTIFICATE OF DEATH

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03893

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Near Finchills
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Finchills
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Annie Evans

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Jacob Evans
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) About 1865
 8. AGE: Years About 80 Months - Days - If less than one day - hrs. - min.

9. Birthplace Dorchester County, Maryland
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business None

FATHER 12. Name Charles Corrish

13. Birthplace Dorchester County, Maryland

MOTHER 14. Maiden name Lockard

15. Birthplace Dorchester County, Maryland

16. Informant Ola Collins

Address Federalburg, Maryland, R.D.

17. Burial Date thereof April 12, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cokebury Cemetery

Location Near Federalburg, Maryland

18. Funeral director J. J. Traubert and Son

Address Federalburg, Maryland

19. April 11 - 1945 - Charles Hastings
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1945 to April 9 1945

and that I last saw him alive on April 16 1945

Immediate cause of death Chronic myocardial Degeneration DURATION 5 yrs. +

Due to Age

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE William C. Harrison MD

Hurlock, Md. M. D. or other 4/9/45

Address - Date signed -

APR 23 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

03894

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:
 County..... Dorchester
 City or town..... Rural--Fishing Creek
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Two Days
 Hospital, institution, or street address where death occurred:
Home of Paul Fuegmann, Fishing Creek
 How long in hospital or institution?..... —

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... New York County..... Green
 City or town..... Cairo
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Jerome Ave.
 (if rural, give LOCATION)
 2(a) If veteran, name war..... —

3. (a) FULL NAME

Max R. Fuegmann

3. (b) Social Security Number

—

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife..... <u>Auga C. Hager</u>			
7. Birth date of deceased (mo., day, yr.) <u>March 27-1882</u>			
8. AGE: Years <u>63</u>	Months <u>—</u>	Days <u>23</u>	6. (c) If alive, give age <u>62</u> years If less than one day hrs. min.

9. Birthplace..... Plaueu, Germany
 (Town, county, and state)
 10. Usual occupation..... Farmer
 11. Industry or business..... Retired

FATHER	12. Name..... <u>Gustav A. Fuegmann</u>
	13. Birthplace..... <u>Germany</u>
	14. Maiden name..... <u>Sophie Rex</u>
MOTHER	15. Birthplace..... <u>Germany</u>

16. Informant..... Mrs. Auga Hager Fruegmann
 Address..... Cairo, New York.

17. Cremation
 (Burial, cremation, or removal. Which?) Date thereof..... April 23, 1945
 (month) (day) (year)
 Cemetery or crematory..... Troy Crematory
 Location..... Troy, New York.

18. Funeral director..... LeCompte's Funeral Service
 Address..... Cambridge, Maryland.

19. 4-21-45
 (Date rec'd by registrar) John Mac...
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20, 1945, at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19....., to 19.....
 and that I last saw him..... alive on 19.....

Immediate cause of death.....	DURATION
<u>Disease of Coronary Arteries</u>	<u>1 day</u>
Due to.....	
Due to.....	
Other conditions.....	
(Include pregnancy within 6 months of death)	

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Dr. K. Shriver, Dep. Med. Exam.
 M. D. or other
 Address..... Cambridge, Md. Date signed..... April 21/45

RECEIVED
APR 23 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH INK-ADINK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of sex is shown on
FILM No. G 95 MAY 28 1945
MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore *32*
CERTIFICATE OF DEATH

03895

Reg. Dist. No. *116*

1. PLACE OF DEATH:
 County... *Rocky Mt.*
 City or town... *Cambridge Md Hospital*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *3 days*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... *Maryland* County... *Caroline*
 City or town... *Preston*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
David Goswelle

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *widower*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *July 16 1867* 6. (c) If alive, give age years

8. AGE: Years *78* Months *9* Days If less than one day hrs. min.

9. Birthplace *md* (Town, county, and state)

10. Usual occupation *none*

11. Industry or business

12. Name *Don't know* STEPHEN GOSWELLEN

13. Birthplace *Don't know* ESTER HUDSON

14. Maiden name

15. Birthplace

16. Informant *Mr Goswelle*
 Address *Choptank*

17. *Burial* Date thereof *April 19 1945*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Choptank*

Location *Choptank*

18. Funeral director *F. B. Willoughby*

Address *East New Market*

19. *4-18* 19 *45* *John M. J. M.D.*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 17* 19 *45* at *3:55 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *4-14* 19 *45* to *April 17* 19 *45* and that I last saw him alive on *April 16* 19 *45*

Immediate cause of death *Coronary occlusion* DURATION *1 hour*

Due to *arteriosclerosis*
Cardiovascular renal disease

Due to *arteriosclerosis* DURATION *2 hrs.*

Other conditions *Congestive Heart Failure*
 (Include pregnancy within 3 months of death)

Major findings of operations *None* Date of op.

Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature *Eldridge Heebly* M. D. or other

Address *Cambridge Md* Date signed *4-17-45*

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APR 23 1949
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

CERTIFICATE OF DEATH

03896

Reg. Dist. No. 110

1. PLACE OF DEATH:

County RochesterCity or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County DorchesterCity or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas J. Hackett

3. (b) Social Security Number

4. SEX

Male

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

July 27 1856

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

889hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Edgman Hackett

13. Birthplace

Md.

14. Maiden name

Catharine Adams

15. Birthplace

Md.

16. Informant

Mrs Geo Thompson

Address

Hurlock

17.

(Burial, cremation, or removal, which?)

Date thereof

April 20 1945
(month) (day) (year)

Cemetery or crematory

Burial Cemetery

Location

Hurlock

18. Funeral director

J. B. Milloughly

Address

Hurlock

19.

April 20 1945
(Date rec'd by registrar)

1945 -

Charles Hackett

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 20 1944 to April 20 1945and that I last saw him alive on April 10 1945Immediate cause of death arteriosclerosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed April 20 1945

RECEIVED
APR 24 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

03897

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 Years
 Hospital, institution, or street address where death occurred:
Cambridge Maryland Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 104 Glasgow St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

William S. Hubbert

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lettie Lloyd Phillips6. (c) If alive, give age 53 years

7. Birth date of

deceased (mo., day, yr.) Nov. 25, 1879

8. AGE:

65 Years4 Months25 Days

If less than one day

..... hrs. min.

9. Birthplace Williamsburg, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business Shirt Factory12. Name Tilghman Hubbert13. Birthplace Maryland14. Maiden name Amada Sherman15. Birthplace Maryland16. Informant Mrs. Wm. S. HubbertAddress 104 Glasgow St., Cambridge, Md.17. Burial Date thereof April 22, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East New Market CemeteryLocation East New Market, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 4-21-1945 Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1945 at 4:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1945 to April 20, 1945and that I last saw him alive on April 20, 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

7 weeks

Due to

Aortic aneurysm

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John Macdonald M.D. M. or otherAddress Cambridge, Md. Date signed 4/21/45

RECEIVED
APR 25 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

CERTIFICATE OF DEATH

Reg. Dist. No. 116

03898

1. PLACE OF DEATH: Dorchester
County.....
City or town.....Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....4 days
Hospital, institution, or street address where death occurred:
Cambridge-Maryland Hospital
How long in hospital or institution?.....4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Infant Hughes

3. (b) Social Security Number

4. Sex Male 5. Color or race negro 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) April 25, 1945
8. AGE: Years Months Days If less than one day
0 0 4 hrs. min.
9. Birthplace Cambridge, Dorchester, Md.
(Town, county, and state)10. Usual occupation.....

11. Industry or business
MOTHER FATHER
12. Name Roland Fletcher
13. Birthplace Maryland
14. Maiden name Florence Hughes
15. Birthplace Maryland

16. Informant Florence Hughes
Address Elkridge, Md.

17. Burial Date thereof April 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Washington Cemetery
Location Hurlock, Md.

18. Funeral director Roland Fletcher
Address Hurlock, Md.

19. April 30, 1945 John Maupf. Md.
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 11:45 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 25 1945 to April 29 1945
and that I last saw h..... alive on April 27 1945

Immediate cause of death.....
Primaturity
Due to Miscarriage
Due to Eclampsia (maternal)
Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations.....
.....Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Harrison MD
M. D. or other
Address Hurlock Md Date signed 4/30/45

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

03899

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

1 Cedar St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Cedar St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Sherman T. Hurley

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Lina Watson6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) June 12, 1868.8. AGE: Years 76 Months 11 Days 1 It less than one day
..... hrs. min.9. Birthplace Copeland, Dor. Co., Maryland
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business

12. Name Thomas Hurley13. Birthplace Maryland.14. Maiden name Gertrude Horseman15. Birthplace Maryland16. Informant William C. HurleyAddress Cambridge, Maryland17. Burial Date thereof April 15, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 4/17/ 19 45 John
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12, 1945 to April 14, 1945
and that I last saw him alive on April 12, 1945

Immediate cause of death

Glaucosia
Coronary Artery
Arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underfoot the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. HurleyAddress Cambridge, Md. Date signed 4-13-1945

RECEIVED

APR 23 1905

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 957

03900

CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH

County Dorchester
City or town East New Market
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Dorchester
City or town E. New Market
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name War

3. (a) FULL NAME

Mrs. Jackson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 25 1889

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

86321

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. April 22 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 21 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/18/45 to 4/21/45and that I last saw him alive on 4/18/45

Immediate cause of death

Chronic myocardial degeneration
General arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

William C. Harrison MD
Harlock Md. Date signed 4/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

03901

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Rochester
 County.....
 City or town..... Cambridge, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Cambridge Md. Hospital
 How long in hospital or institution?..... 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Rochester
 City or town..... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
William Edgar Krouse

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace..... Cambridge
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Frederick Paul Krouse13. Birthplace..... Huntington Co. Pa.14. Maiden name..... Shelma Whitesel15. Birthplace..... Pa.16. Informant..... Frederick Paul KrouseAddress..... Cambridge, Md.17. Burial Date thereof..... April 10, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... GreenlawnLocation..... Cambridge18. Funeral director..... Kenneth R. ThomasAddress..... Cambridge, Md.19. 4-10- 1945 John MacCaffrey, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 7 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6 1945 to April 7 1945and that I last saw him/her alive on April 7 1945

Immediate cause of death.....

Atelectasis lungs

DURATION

30 hoursDue to..... Septic toxemia motherProgress of case.Due to..... PrematurityOther conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... M. J. ThomasAddress..... Cambr. Md. Date signed..... 4/9/45

M. D. or other

RECEIVED

APR 17 1945

BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03902

1. PLACE OF DEATH

County WorcesterVillage or City Reliance

No.

St.

Ward

Length of residence in city or town where death occurred 50 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Christiana H. Lankford

If U. S. Veteran, specify WAR

(a) Residence: No.

Reliance

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of (or) WIFE of

Franklin Lankford

6. DATE OF BIRTH (month, day, and year)

7-30-1875

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69816

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Own home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

April 194550

12. BIRTHPLACE (city or town)

Eldorado

(State or country)

Maryland

FATHER

13. NAME

Joseph Sheatley

14. BIRTHPLACE (city or town)

Eldorado

(State or country)

Maryland

MOTHER

15. MAIDEN NAME

Martha White

16. BIRTHPLACE (city or town)

Eldorado

(State or country)

Maryland

17. INFORMANT

Franklin Lankford

(Address)

Reliance, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Cokesbury, Md. Date Apr. 18, 1945

19. UNDERTAKER

Medford L. Hatton Jr.

(Address)

Seaford, Del.

20. FILED

April 16, 1945Charles Hastings

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Apr 15

(Month)

(Day)

1945 (Year)

22.

I HEREBY CERTIFY That I attended deceased from

Sept 9, 1942, to Apr 12, 1945I last saw him alive on Apr 12, 1945; death is said

to have occurred on the data stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage
White matter at
right

Date of onset

Apr 13, 45

Other Contributory Causes of Importance:

Chronic Myocarditis

Name of operation

Date of

When test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

W. E. Harrison

M. D.

(Address)

Seaford, Del.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

03903

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester
 City or town..... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... all of life
 Hospital, institution, or street address where death occurred:
7 Slacum St.
 How long in hospital or institution?..... X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester
 City or town..... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 7 Slacum St.
 (If rural, give LOCATION)
 2.(a) If veteran, name War.....

3. (a) FULL NAME

Gary Mack

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... colored B. (a) Single, married, widowed, or divorced..... single
 B. (b) Name of husband or wife..... X
 7. Birth date of deceased (mo., day, yr.)..... March 20, 1945
 8. AGE: Years..... X Months..... X Days..... 20 It less than one day..... hrs. min.

9. Birthplace..... Cambridge, Maryland
 (Town, county, and state)
 10. Usual occupation..... none

11. Industry or business..... X

FATHER 12. Name..... William Batson
 13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Beatrice Mack
 15. Birthplace..... Maryland

18. Informant..... Beatrice Mack
 Address..... 7 Slacum St.- Cambridge, Md.

17. Burial Date thereof..... April 12/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Cemetery
 Location..... Cambridge, Md.

18. Funeral director..... Sevier & Son, Inc.
 Address..... Cambridge, Md.

19. 4-11- 19 45 J. R. Mack, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 9 19 45, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... X 19....., to..... X 19.....
 and that I last saw him..... alive on..... X 19.....

Immediate cause of death..... Congenital Malformation
of the heart
 DURATION..... 2 days

Due to..... X
 Due to..... X

Other conditions..... X

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. R. Shivers, Dep. Med. Exam.
 M. D. or other
 Address..... Cambridge, Md. Date signed..... Apr 9/45

RECEIVED
APR 17 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-M

CERTIFICATE OF DEATH

Reg. Dist. No. 116

03904

1. PLACE OF DEATH:

County... DorchesterCity or town... Rural Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Cambridge RFD #3How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Rural Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No... RFD # 3
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Henry Clay Marshall

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife... Emma J. Peters6.(c) It alive, give age 71 years7. Birth date of deceased (mo., day, yr.) Feb. 9, 1871.

8. AGE:

Years

Months

Days

It less than one day

74128

hrs. min.

9. Birthplace... Nr. Cambridge, Dor. Co., Md.
(Town, county, and state)10. Usual occupation... Farmer11. Industry or business... Dirt12. Name... George N. Marshall13. Birthplace... Maryland14. Maiden name... Sarah J. Marshall15. Birthplace... Maryland16. Informant... Mrs. Carroll ThomasAddress... Cambridge, Maryland.17. Burial Date thereof April 9, 1945
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory... Speddans CemeteryLocation... James, Maryland.18. Funeral director... LeCompte Funeral ServiceAddress... Cambridge, Maryland.19. 4-9-45 John Marshall
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 7, 1945, at 5:15A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 20 19 45 to April 7 19 45
and that I last saw him alive on April 6 19 45

Immediate cause of death

DURATION

Gastro Intestinal
Due to Malignant Growth 2 yrs.

Due to

Other conditions Profound Secondary
Dissemination 1 year
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldridge H. Hefelford MDAddress... Cambridge Md M. D. or other 4-9-45
Date signed

RECEIVED
APR 17 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-2

CERTIFICATE OF DEATH

Reg. Dist. No. 115

03905

1. PLACE OF DEATH:

County Dorchester CountyCity or town Craps Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life Time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Craps
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Serena McCreedy

3. (b) Social Security Number

254. Sex Female 5. Color or race Colord 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Orlie McCreedy

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar 3, 18968. AGE: Years 49 Months 1 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Craps md
(Town, county, and state)10. Usual occupation Labor

11. Industry or business

12. Name William A. Johnson13. Birthplace Craps md14. Maiden name Garre McCreedy15. Birthplace Craps md16. Informant Julia JenniferAddress 4 School House Lane17. Burial Date thereof April 12 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Craps CemeteryLocation Beach Ground18. Funeral director L H B ApplebyAddress 201 W. Chelington19. Apr 10 1945 James W. Meade
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 12:50 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1945 to April 9 1945and that I last saw him alive on April 8 1945Immediate cause of death Acute Endocarditis DURATION 1 mo.Due to Acute Rheumatic Fever 2 mo.Due to Chronic Rheumatic Arthritis 5 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James W. Meade M.D.Address Fishing Creek Date signed Apr 10 1945

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APR 23 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

03906

Reg. Dist. No. 116 119

1. PLACE OF DEATH:

County Dorchester
City or town Bishops Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Drowned near Home
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Bishops Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bishops Head
(If rural, give LOCATION)
2. (a) If veteran, name war -

3. (a) FULL NAME

Victor S. Pritchett

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Florence E. Murrell

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1897. 6. (c) If alive, give age 46 years

8. AGE: Years 47 Months 7 Days 0 If less than one day - hrs. - min.

9. Birthplace Bishops Head, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Zekelou Pritchett

13. Birthplace Maryland

MOTHER 14. Maiden name Martha W. Pritchett

15. Birthplace Maryland

16. Informant Mrs. Victor Pritchett

Address Bishops Head, Maryland.

17. Burial Date thereof April 15, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Thomas Cemetery

Location Bishops Head, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. April 15 1945 Wilson D Pritchett
(Day, rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19-, to - 19-

and that I last saw h. - alive on - 19-

Immediate cause of death Drowning - Accidental DURATION 4

Due to X

Other conditions X

(Include pregnancy within 3 months of death)

Major findings of operations X

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of April 13/45

Where did injury occur? Waters Island (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in Hanga River

Means of injury Drowning Injured at work? yes

23. SIGNATURE Dr. H. Shivers, Dep. Med. Exam. M. D. or other

Address Cambridge - Md. Date signed April 14/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 26 1965
BUREAU V.8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03907

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Taylor's Island
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Home---Taylor's IslandHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Taylor's Island
(If outside city or town limits, write RURAL and give nearest town)Street No. Taylor's Island
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Augustus c. Ruark

3. (b) Social Security Number

-4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mattie Ruark (Deceased)6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) April 18, 18728. AGE: Years 72 Months 11 Days 21 It less than one day - hrs. - min.9. Birthplace Taylor's Island, Dor. Co., Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Dirt12. Name John W. Ruark13. Birthplace Maryland14. Maiden name Jane Adams15. Birthplace Maryland16. Informant John RuarkAddress Taylor's Island, Maryland.17. Burial Date thereof April 11, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brick Church CemeteryLocation Taylor's Island, Md.18. Funeral director Lecompte's Funeral ServiceAddress Cambridge, Maryland.19. 4-10-45 John W. Ruark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945 at 10:20 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1945, to April 9 1945and that I last saw him alive on April 8 1945Immediate cause of death Cerebral Hemorrhage DURATION 4 daysDue to Hypertension 1 yrDue to -Other conditions Chronic Hypertension 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Dr. R. H. Smith M.D. M. D. or otherAddress Cambridge, Md. Date signed Apr 10/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 17 1945
BUREAU U.S.

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MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

03908

Reg. Diat. No. 116

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 Muir Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fannie Estella St. Clair
3.(b) Social Security Number

4. Sex Female
5. Color or race Negro
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife H. M. St. Clair

7. Birth date of deceased (mo., day, yr.) June 26, 1877
8.(c) If alive, give age 76 years

8. AGE: Years 67 Months 9 Days 10
If less than one day hrs. min.

9. Birthplace Crisfield, Som. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name John Wilson

13. Birthplace Crisfield, Som. Co. Md.

14. Maiden name Harriet (Unknown)

15. Birthplace Crisfield, Som. Co. Md.

16. Informant H. M. St. Clair

Address Cambridge, Md.

17. Burial Burial Date thereof Apr. 10 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Wauoh Cemetery

Location Cambridge, Md.

18. Funeral director H. M. St. Clair and Son

Address Cambridge, Md.

19. (Date rec'd by registrar) 4-9-45 Registrar John M. J. [unclear]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 5:40 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 6 1945 and that I last saw him alive on April 6 1945

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll W. St. Clair, M.D.
M. D. or other

Address Cambridge, Md. Date signed 4-9-45

RECEIVED
APR 17 1945
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03909

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester
 County Cambridge
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 213 Choptank Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME Russell Z. Tall

3. (b) Social Security Number none

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Lula Lee Stewart
 6.(c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) 5/10/1894
 8. AGE: Years 50 Months 11 Days 7 If less than one day
 hrs. min.

9. Birthplace Cambridge
 (Town, county, and state)
 10. Usual occupation Seaman

11. Industry or business
 12. Name John Z. Tall
 13. Birthplace Dor Co
 14. Maiden name Alexina Harper
 15. Birthplace Dor Co.

16. Informant Herbert Tall
 Address Cambridge, Md.

17. Burial Date thereof 4/20/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Dorchester Memorial
 Location Cambridge, Md.

18. Funeral director Kenneth R. Thomas
 Address Cambridge, Md.

19. 4-18- 19 45 John Mace Jr.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 45 at 5:40 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 44 to April 17 19 45
 and that I last saw him alive on April 17 19 45
 Immediate cause of death Coronary Thrombosis DURATION 6 hrs
 Due to Patina Bronchitis 6-10 yrs
 Due to
 Other conditions Cardiac Dilatation 2 days
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur?
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. K. Smith Dr. M. E. Carr
 M. D. or other
 Address Cambridge, Md. Date signed April 18, 1945

RECEIVED
APR 23 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Dorchester
 City or town.....Cambridge, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....209 Race St.
 (If rural, give LOCATION)
 2.(a) ff veteran, name war.....none

3. (a) FULL NAME Frank T. Thorne

3. (b) Social Security Number none

4. Sex Male 5. Color of race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Lillie May Cuddy
 7. Birth date of deceased (mo., day, yr.) April 18 - 1867 5. (c) If alive, give age 71 1/2 years
 8. AGE: Years 78 Months 0 Days 11 If less than one day
 hrs. min.

9. Birthplace.....Waynesville Ohio
 (Town, county, and state)
 10. Usual occupation.....General Valet Mgr.
 11. Industry or business.....Burial Vaults
 12. Name.....Alexander Thorne
 13. Birthplace.....Ohio
 14. Maiden name.....Throckmorton
 15. Birthplace.....Ohio

16. Informant.....Frank C. Thorne
 Address.....Cambridge, Md.
 17. Burial Date thereof.....May 1 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Dorchester Memorial Park
 Location.....Cambridge, Md.
 18. Funeral director.....Kenneth R. Thorne
 Address.....Cambridge, Md.

19. May 1st 45 John Maciej M. D. Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Apr 29 - 1945 at 7:15 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1942 to Apr 29 1945
 and that I last saw him alive on April 28 1945
 Immediate cause of death.....Coronary

22. DURATION.....12h
 Due to.....Coronary. Rival
 Due to.....vascular disease
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....none
 Date of op.....none
 Autopsy results.....none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....John Maciej M. D.
 Address.....Cambridge, Md.
 Date signed.....7-30-1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03911

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 87 years
 Hospital, institution, or street address where death occurred:
Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town East New Market
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Eben W. Wheatley

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower
 6.(b) Name of husband or wife A. Mae Wheatley
Deceased 6.(c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) April 15, 1859
 8. AGE: Years 86 Months 11 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace East New Market, Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Elihu Wheatley
 13. Birthplace East New Market, Md.

MOTHER 14. Maiden name Mary Stevens
 15. Birthplace East New Market, Md.

16. Informant Eben W. Wheatley (Son)
 Address East New Market, Md.

17. Burial 4-11-45
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory East New Market Cemetery
 Location East New Market, Md.

18. Funeral director H. H. Hirzel
 Address Wilmington, Del.

19. 4-10-45 John M. J. M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 2: P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1945 to 4/8 1945
 and that I last saw him alive on 4/8 1945

Immediate cause of death Myocardial Failure DURATION 4 days.

Due to Hypertensive cardiovascular disease

Due to Senility

Other conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none.
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. J. K. M.D. M.D. or other 4/10/45
Cambridge Md Date signed _____
 Address _____

CERTIFICATE OF DEATH

RECORDED
APR 17 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 556

03912

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 208 Penn St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wallace Milton Wheatley

3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mary Wheatley6.(c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) April 12 18988. AGE: Years 46 Months 11 Days 24 If less than one day hrs. min.9. Birthplace Beekwith Dr. C Md
(Town, county, and state)10. Usual occupation Chapman

11. Industry or business

12. Name John Jackson13. Birthplace Dorchester C Md14. Maiden name Clara Sharp15. Birthplace Dorchester C Md16. Informant Mary WheatleyAddress 208 Penn St Cont 11417. Burial Date thereof Apr 15 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wauke CemeteryLocation Cambridge Md18. Funeral director H. M. St. Clair and SonAddress Cambridge, Md.19. 4-11-1945 John Mace Jr. MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 22 1945 to April 11 1945and that I last saw him alive on April 11 1945Immediate cause of death Sarcoma left hip

DURATION

4 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll M. Steele MD
M. D. or otherAddress Pen Tada St Date signed 4-13-45

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APR 23 1945
BUREAU V.S.